TRAUMA MATTERS

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INSIDE THIS ISSUE:

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BECOMING TRAUMA INFORMED
- ONE NETWORK'S EXPERIENCE-

About seven years ago, the Torrington area office of the Western Connecticut Mental Health Network (WCMHN) was designated as a Department of Mental Health and Addiction Services Trauma Center of Excellence. That designation was both a recognition of the work we were doing and a motivator for us to continue to improve our services.

Understanding the role of trauma in the lives of those who seek behavioral health care is essential to effective treatment. As this realization became more prevalent, the statewide Trauma Advisory Committee in 2002 established criteria for trauma treatment models, resulting in the selection of three treatment models for training: Trauma Recovery and Empowerment (TREM), Seeking Safety, and Trauma Adaptive Recovery Group Education and Therapy (TARGET). The selection of these three models, plus the subsequent addition of several other modalities, widened the clinical options.

Ensuring the availability of trauma-specific services was the important first step. In 2004, the Trauma Advisory Committee decided that all behavioral health care services needed to be trauma-informed. At WCMHN, working with Roger Fallot of Community Connections in Washington, DC, we embarked on a transition to provide an environment based on safety, trustworthiness, choice, collaboration, and empowerment. This multilevel change at WCMHN was inclusive of all staff as well as the providers who receive grants from DMHAS in our geographical area.

Waiting room after changes.

Larger waiting room has better lighting and movable individual chairs.

After seven years, we take pride in the improvements to our services while we continue to make necessary changes. Our staff is more attuned to the importance of looking at those to whom we provide services through a "trauma lens." By making the assumption that most people seeking services have experienced trauma, we can use the skills we have gained to "do no harm" and do the greatest good. Some concrete examples of changes made at WCMHN over the past seven years: *(CONTINUED ON PAGE 2)*

BECOMING TRAUMA INFORMED

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Previous Practice	*Current Practice*
Small waiting room with couch	Larger waiting room has better lighting and movable individual chairs.
Intake process was not fully explained	The intake process is explained, and each client receives a tour of the facility.
Intake rooms had institutional furnishings	Furnishings are comfortable, rooms are nicely decorated, and staff do not sit behind a desk.
Staff told clients what treatment would be best for them	Treatment options are explained, and clients choose the services they will receive.
Client involvement in the organization's work was minimal	There is much more client input. For example: clients sit on most standing committees, and clients participated in selection of interior paint colors.
Staff members were not always aware of practices that could be re-traumatizing	Staff now view services, situations, and activities through a trauma lens. For instance: paying attention to unlit areas, such as bathrooms and parking lots.

Through the use of consultation and technical assistance, we have developed a trauma-sensitive service system where the impact of trauma and trauma recovery is integrated into all aspects of service delivery. At the same time, more work needs to be done. Some areas we continue to focus on include:

- Providing all new staff with training in psychological trauma as well as training in self-care to minimize burnout
- Continually identifying negative or re-traumatizing behavior and then changing practice
- Realizing when we do not allow a client to exercise personal choice in seeking and engaging in services and then course correcting
- Remembering to include trauma-informed approaches in all facets of service delivery
- Further enhancing supervision competencies that show an understanding of trauma and its effects

Staff from WCMHN continue to engage in activities geared toward improving the delivery of trauma-informed services statewide. We attend the quarterly Trauma Committee meetings, participate in the monthly Trauma Guide Team meetings, contribute to the Trauma Matters newsletter, and we will actively participate on February 28, 2012 in Trauma Advocacy Day, "*Trauma: From Surviving to Thriving,*" to be held at the Legislative Office Building in Hartford.

For more information about Trauma Advocacy Day or to learn how to be part of the statewide trauma initiative, contact *Roslyn Williams at 203.909.6888 Ext. 25.* WCMHN's journey to becoming trauma-informed has been and continues to be both challenging and rewarding; we encourage you to join us on this path.

Article submitted by Colette Anderson, LCSW, Chief Executive Officer,
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Trauma-Informed Gender Responsive Care:
Implementing and Evaluating Change

In the Fall 2011 *Trauma Matters* newsletter, readers were given a full account of the ways in which trauma-informed care has evolved in the state of Connecticut over the last decade. A recent report by the Connecticut Department of Mental Health and Addiction Services[1] included trauma-related screening responses from more than 25,000 clients in 2011. The results indicated that almost 30 percent of clients from a variety of mental health agencies across Connecticut had a history of exposure to traumatic events and were experiencing symptoms related to that trauma in the past month. Given that nearly one in three behavioral health clients in the state report experiencing current trauma-related symptoms, agencies will improve service delivery by creating a trauma-informed environment. After several years of focusing on creating cultures of trauma-informed care, in 2009, Connecticut took this initiative a step further, by adding gender-responsiveness to its core values-based approaches. We know that not only are men and women exposed to different kinds of traumatic events but that they characteristically respond differently to trauma and violence. Taking gender differences into account has been a new challenge for many programs in our state. This article describes the process of evaluation and transformation agencies undergo as part of the Request For Qualifications (RFQ) process awarded by the Connecticut Women's Consortium and DMHAS.

In the present grant cycle, two agencies (Wheeler Clinic in the Greater Hartford area and Recovery Network of Programs in the Bridgeport area) were selected from among those that applied through a competitive process to be part of the current Trauma-informed and Gender-responsive (TiGr) Care Training and Evaluation Grant. These agencies have made a commitment to become as fully trauma-informed and gender-responsive as possible. As part of the grant award, agency staff members were provided with training and ongoing technical assistance by Stephanie Covington, PhD, LCSW; Roger Fallot, PhD; and Eileen Russo, LCSW.

The focus of the evaluation is to assess multiple agency stakeholders and provide a variety of perspectives at baseline and again at the end of the grant cycle. The newest part of the evaluation is the intake and "walk through." The research team included two extraordinary peer advocates who are graduates of the program at Advocacy Unlimited/Recovery University. Adam Osmond and Jean Monroe completed all six initial walk-through evaluations. The peers took turns in the roles of potential client and supportive friend. Having both a male and female viewpoint proved very useful in the perspectives each brought to the process and served as a reminder of the gender differences frequently experienced in the intake process.

Along the way, we have learned several important lessons. The first is that although the walk-through evaluation is meant to be an assessment of the process, clinicians are also vulnerable to anxiety when observed. Clarity about the nature of the evaluation cannot be underestimated. Further, it is important that the peers be significantly along in their recovery to undergo a thorough psychosocial intake process, which can be emotionally draining and may potentially leave the peer advocate in a vulnerable state.

The researcher who accompanied the peer advocates primarily served as a note taker during the intake process. The researcher then processed each experience immediately after the walk through and once again when the peers had some time to reflect on their experiences. Having a clinical background as well as research experience was essential for this responsibility. Checking in and debriefing with each peer advocate was important in capturing their authentic reactions while ensuring that there was no negative impact as a result of the experience.

Following the model created by Roger Fallot and Stephanie Covington, the evaluation process also involves a written survey of staff and agency clients. In addition, the research team conducts focus groups comprised of agency clients.

Feedback is provided to each agency in context of the five domains (safety, trustworthiness, choice, collaboration, and empowerment) of the Fallot/Harris Model. This feedback serves as additional information for the TiGr committees created by each organization to consider when planning agency-wide trauma-informed and gender-responsive changes.

[1]Connecticut Department of Mental Health and Addiction Services, "DMHAS Clients Who Screened Positive for Trauma in FY 2011," January 17, 2012.

Amy James, PhD, Research Associate Professor, UConn School of Social Work
Department of Mental Health and Addiction Services

From a Client's Perspective...

Broken Glass

The complexity of the human mind and the human soul can be hard to understand
Sometimes the mind and soul break like a piece of glass
There are times when a broken piece of glass needs extra support
to come together again and sustain itself
The pieces come together slowly, never look quite the same as before
But now stronger because this unique piece of glass has had a choice about how it will look
Does this make the piece of glass different?
Yes!
Does this make the piece of glass of lesser value just because it has been broken?
I think not!
The view from behind a broken piece of glass that has come together again can be
beautiful, unique, and yes, sometimes painful
So it is with the human mind—the human heart—the human soul
So, if given the opportunity to offer support and help someone's pieces come together again…
Do it!!!
You will have the chance to be a part of creating a person of beauty
both inward and outward

-Anonymous-

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The Connecticut Women's Consortium
Improving Behavioral Health Services for Women

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Connecticut
Department of Mental Health and Addiction Services
A Healthcare Service Agency